PRINTED: 08/16/2011

DEPARTMENT	Γ OF HEALTH AND HUN	MAN SERVICES				FO	RM APPROVED
CENTERS FOI	R MEDICARE & MEDIC	AID SERVICES				OM	IB NO. 0938-0391
	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155412	B. WIN			07/15/2	2011
NAME OF I	PROVIDER OR SUPPLIER	₹		1	ADDRESS, CITY, STATE, ZIP CODE		
ODEENIN	MOOD HEALTH AN	D. L. IVIINIC COMMANDINITY L. L. C.		937 FR			
		D LIVING COMMUNITY LLC			NWOOD, IN46142		
(X4) ID		STATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5)	
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		TE.	COMPLETION DATE
F0000	REGUE/HORT OR	LEGE IDENTIFICATION INFORMATION		1710			DAIL
10000							
	This visit was for Recertification and		FO	0000	This plan of correction is to)	
	State Licensure survey.				serve as Greenwood Healtl	1	
		3			and Living Community's		
	 Survev dates: Ju	ly 11th, 12th, 13th, 14th,			credible allegation of compliance. Submission of		
	and 15th, 2011				this plan of correction does		
					constitute an admission by		
	Facility number: 000509				Greenwood Health and Liv		
	Provider number				Community or their		
	AIM number: 1				management companies th		
		0020020			the allegations contained in survey report are a true an		
	Survey team: Le	ia Alley, RN, TC			accurate portrayal of the		
	1 *	arcy Smith, RN			provision of nursing care a	nd	
		rbara Hughes, RN			other services in this facilit	y.	
		rina Gates, BHS			Nor does this submission		
					constitute an agreement or admission of the survey	,	
	Census bed type	•			allegations.		
	SNF/NF: 98						
	Total: 98						
	Census payor ty	pe:					
	Medicaid: 69	r ··					
	Medicare: 16						
	Other: 13						
	Total: 98						
	Sample: 20						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.

Quality review completed 7/20/11

TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

ZYOR11

Facility ID:

000509

If continuation sheet

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING 00			(X3) DATE SURVEY COMPLETED	
		155412	B. WIN	G		07/15/2	011
	PROVIDER OR SUPPLIER	D LIVING COMMUNITY LLC	•	937 FR	ADDRESS, CITY, STATE, ZIP CODE Y RD IWOOD, IN46142		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) RN		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
F0282 SS=E	facility must be proin accordance with plan of care. 1. Based on record the facility failed for diabetes were sugars being called insulin being adnuted 4 of 4 residents region in a sample of 20 #48 and #20) 2. Based on intention the facility failed not continue to region it was discontinue of 17 residents region physician's order (Resident #25) 3. Based on observed review the aresident on a nor receive added sal reviewed for recedite order recomme (Resident #52) 4. Based on record the facility failed not continue to region in the facility failed not continue to receive added sal reviewed for receive added sal r	ded or arranged by the ovided by qualified persons a each resident's written and review and interview to ensure plans of care followed for blood ed to the physician and ministered as ordered for eviewed for diabetic care. (Residents #94, #41, which will be a medication after ed by the physician for 1 viewed for following in a sample of 20. Envation, interview, and a facility failed to ensure a added salt diet did not a for 1 of 12 residents environg the appropriate mended by the physician.	FO	0282	F282 483.20(k) (3) (ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAI I. Resident #25's Metoclopramide was discontinued on 7/12/11. Resident #52's diet was clarified with the physician during the survey process the NAS order was discontinued. Resident #52 receiving a diet as ordered the physician. Any blood so out of ordered parameters residents #94, #41, #48 and are being called to the physician. Resident #107 no longer resides at this facilif II. Any resident with pharmacy medication recommendation for the last days will be audited for completion. All resident die will be audited to cross reference diet slips and physician orders for accura All residents with blood su and insulin orders will be reviewed for notification of physician and administratio of insulin. All NPO (nothing mouth) residents have been	and is by ugar for #20 o y. a st 30 sts ncy. gar	08/14/2011

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155412		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE COMPI 07/15/2	LETED	
	PROVIDER OR SUPPLIER	LIVING COMMUNITY LLC	STREET A	ADDRESS, CITY, STATE, ZIP CODE Y RD IWOOD, IN46142		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	ON BE PRIATE	(X5) COMPLETION DATE
	mouth, did not real of 1 resident in physicians orders mouth). Findings include 1.a) The record reviewed on 7/12 Diagnoses for Real were not limited end stage renal did a physician's ordindicated the rest accuchecks (a firmeasure blood stage accuchecks (a firmeasure blood stage) and the stage renal did a physician was to resident's blood stage than 60 or over 2 A care plan for Resident's blood stage plan fo	of Resident #94 was 2/11 at 8:50 a.m. esident #94 included, but to, diabetes mellitus and isease. der a dated 5/3/11, ident was to receive agerstick blood test to agar) twice a day on sday and Friday and the be notified if the sugar reading was less 2:50. desident #94 dated dated dated for a problem of "Risk for mia [low/high blood		audited for accuracy of documentation/administ of fluids and none were III. The systemic concludes: a. All pharmacy recommendations will be to and monitored by the Director of Nursing or designee. The Director of Nursing or designee will distribute recommendate the unit managers and a will be returned to the Dof Nursing or designee, monitor for completion. b. All physician orders reviewed in daily clinicate up meeting for commune with dietary department. c. All blood sugar resultance in a new format on the medication administration record and diabetic testing log has placed in the medication administration record for documentation of blood outside parameters and physician notification. Previous blood glucose log has been removed. d. All sliding scale instorders have been placed in the medication. Previous blood glucose log has been removed. d. All sliding scale instorders have been placed in the medication. Previous blood sugar result and the amount or include time, blood sugar result and the amount or insulin given. e. The charge nurses	found. hange e given of ions to copy irector to will be I stand ication ults ew n od been r sugars testing ulin I in a cation	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION (X3) I			JRVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	LDING	00	COMPLE'	TED
		155412	B. WIN			07/15/20	11
		1	B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8		937 FR			
GREEN	NOOD HEALTH AN	D LIVING COMMUNITY LLC		1	IWOOD, IN46142		
				L			
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	†	LSC IDENTIFYING INFORMATION)	+	TAG	·	+	DATE
		sident's Diabetic Testing			include monitoring of Matri fluid documentation for	x	
	Log for May, 20	11, indicated the			residents with NPO orders	.	
	following:				their end of shift duties.	"	
	5/4/11 at 4:00 p.:	m. blood sugar = 282			Education will be provided	to	
	5/21/11 at 6:00 a	i.m. blood sugar = 252			licensed nursing staff on th		
		o.m. blood sugar = 289			new pharmacy		
	1 *	sident's Diabetic Testing			recommendation procedure	e,	
		C			dietary orders and		
	_	11, indicated the			communication, diabetes		
	following:				management and		
		m. blood sugar = 292			documentation, and Matrix		
	6/14/11 at 4:00 p	o.m. blood sugar = 267			documentation as it relates	to	
					residents who are NPO.		
	There was no do	cumentation in the			IV. The Director of		
	resident's record	to indicate the physician			Nursing or designee will		
		about these elevated			review/audit: a. The pharmacy		
		ich were outside the call			recommendations for		
	1	ien were outside the ean			completion once weekly on	an	
	parameters.				ongoing basis.	· "	
					b. Diet orders changes ar	nd	
					new admission diet orders		
	1 '	of Resident #20 was			clinical stand up meeting w	rith	
	reviewed on 7/14	4/11 at 2:00 p.m.			Certified Dietary Manager o	r	
					designee for accuracy with	diet	
	Diagnoses for Re	esident #20 included, but			cards five times weekly an		
	"	to, diabetes mellitus and			ongoing basis.		
	hypoglycemia.				c. Medication administra	tion	
	inypogrycenia.				records to include diabetic		
	A reconitulated =	abraicionia order for Iulia			testing log will be audited f blood sugar results, physic		
		ohysician's order for July,			notification, and amount of		
		iginal date of 1/3/10,			insulin given five times wee		
		ident was to get a "finger			for 1 month, then three time	- 1	
	stick blood sugar	r 4 times daily."			weekly for 1 month, then or		
					weekly for 1 month, then or		
	A recapitulated r	physician's order for July,			monthly for duration of 12		
		iginal date of 8/13/10,			months.		
					d. Matrix fluid documenta	tion	
	indicated the resident was supposed to						

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155412	A. BUILDING	00	COMPLETED 07/15/2011
		100412	B. WING	ADDRESS STEW STATE ZID CODE	0771072011
NAME OF I	PROVIDER OR SUPPLIER		937 FF	ADDRESS, CITY, STATE, ZIP CODE	
		D LIVING COMMUNITY LLC		NWOOD, IN46142	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE
IAG		Insulin, based on the	IAG	for NPO residents five time	
	ı	ger stick, according to the		weekly for 1 month, then the	
	following sliding	, ,		times weekly for 1 month,	I
	Blood sugar = 12			once weekly for 1 month, t	I
	Blood sugar = 15			once monthly for duration	of 12
	Blood sugar = 17			months. The results of these review	ue
	Blood sugar = 20			will be discussed at the	,,,
	Blood sugar = 22			monthly facility Quality	
	Blood sugar = 25			Assurance Committee mee	<u> </u>
	Blood sugar = 27			and frequency and duratio	
	Blood sugar = 30			reviews will be adjusted as needed.	
	Blood sugar = 32			V. Completion date:	
	Blood sugar $= 35$			August 14, 2011.	
	Blood sugar = 37				
	Blood sugar over				
	Blood Sugai over	1 400. Call MD			
	Review of Diabe	tic Testing Log for June,			
		he following finger stick			
	results:				
	6/5/11 at 6:00 a.r	m. blood sugar = 135 - 2			
		e been given and were			
	not.	-			
	6/7/11 at 6:00 a.r	m. blood sugar = 163 - 3			
	units should have	e been given and were			
	not.				
	6/12/11 at 6:00 a	.m. blood sugar = $136 - 2$			
	units should have	e been given and were			
	not.				
	6/19/11 at 6:00 a	.m. blood sugar = $209 - 5$			
	units should have	e been given and were			
	not.				
	Review of the Ju	ne, 2011 Medication			
	Record did not i	ndicate any insulin was			

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	OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			INSTRUCTION 00	(X3) DATE S	
		155412	A. BUII B. WIN			07/15/2	
	PROVIDER OR SUPPLIER		P . WIIV	STREET A			
	_	D LIVING COMMUNITY LLC		GREEN	IWOOD, IN46142		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	given to the resident for the above fingersticks according to the sliding scale.						
	7/15/11 at 10:00 did not know if a	ew with the DoN on a.m. she indicated she ny insulin was given to the above blood sugars.					
	1.c) The clinical record for Resident #48 was reviewed on 7/15/11 at 9:45 a.m.						
	Diagnoses for Resident #48 included, but were not limited to: Diabetes Mellitus, Hypertension, Anemia, Dementia with Psychosis, and Depression.						
	orders indicated an Accucheck (a the glucose level at 6 a.m. and 4 p. the physician wa results were less The orders indica Novolog Insulin 3 times daily (7:35:30 p.m.). The Insulin to be give on the results of follows: 150-200	of July, 2011 physician's Resident #48 was to have blood test to determine in the blood) twice daily m. The orders indicated is to be contacted if the than 60 or above 350. In the theorem in the resident received 16 Units subcutaneously 30 a.m., 12:00 p.m., and orders indicated Novolog on per sliding scale based the Accucheck test as 0=2 Units, 201-250=4 5 Units, and 301-350=8					

		X1) PROVIDER/SUPPI		(X2) MU	LTIPLE CO	NSTRUCTION		(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUM	MBER:	A. BUIL	DING	00		COMPL	
		155412		B. WING	i			07/15/2	011
NAME OF F	PROVIDER OR SUPPLIER			<u> </u>	STREET A	DDRESS, CITY, STA	ΓE, ZIP CODE		
					937 FR				
GREENV	VOOD HEALTH ANI	D LIVING COMMU	JNITY LLC		GREEN	WOOD, IN46142	2		
(X4) ID	SUMMARY S	TATEMENT OF DEFICI	ENCIES		ID		LAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PERCEDI		I	PREFIX	CROSS-REFERENCE	E ACTION SHOULD BE D TO THE APPROPRIAT	E	COMPLETION
TAG		LSC IDENTIFYING INI		-	TAG	DEFI	CIENCY)		DATE
	The diabetic testi	• •							
	indicated the resident's blood sugars were								
	checked and in the range requiring insulin								
	coverage per sliding scale on the								
	following dates and times:								
	7/2/11 - 4 4 00	100	0.11						
	7/2/11 at 4:00 p.m. = 180 2 Units should have been administered and were								
		administered an	ia were						
	not.	170	0 II. '4						
	7/3/11 at 4:00 p.r		2 Units						
	should have been administered and were								
	not.	220	4.77						
	7/7/11 at 4:00 p.r		4 Units						
	should have been	i administered an	id were						
	not.	• 0 6	4 *** *						
	7/13/11 at 6:00 a		4 Units						
	should have been	administered an	nd were						
	not.								
	The dishering to sai		•						
	The diabetic testi	~ ~							
	(medication adm		/						
	any information	•							
	coverage per slid								
	given as ordered		based						
	on the results not	ted above.							
	The dishetic testi	ing log indicated	a blacd						
	The diabetic testi								
	sugar result of 17								
	The MAR indica								
	were given and s								
	The diabetic testi								
	sugar result of 266 on 7/10/11 at 4:00 p.m. The MAR indicated 4 Units of insulin								
	were given and s	nould have been	6 Units.						
FORM CMS-2	2567(02-99) Previous Versio	ns Obsolete	Event ID:	ZYOR11	Facility I	D: 000509	If continuation sh	eet Pa	ge 7 of 30

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO.	NSTRUCTION 00	(X3) DATE COMPI		
THIE TETHY	or condition	155412	1 ' '	LDING		07/15/2	
		100112	B. WIN	_	DDDESS CITY STATE ZID CODE	0171072	
NAME OF I	PROVIDER OR SUPPLIER			937 FR	ADDRESS, CITY, STATE, ZIP CODE		
GREENV	VOOD HEALTH AN	D LIVING COMMUNITY LLC		1	WOOD, IN46142		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTIO	N	(X5)
PREFIX TAG	·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROP DEFICIENCY)		COMPLETION DATE
IAG			+	IAG			DATE
		ing log indicated a blood 15 on 7/15/11 at 6:00 a.m.					
	"	ted 3 Units of insulin					
		hould have been 4 Units.					
	were given and s	modia nave occii 4 Omis.					
	1.d) The clinical	record for resident #41					
	was reviewed on	7/14/11 at 2:30 P.M.					
	A Health Care Pl	an problem dated 3/3/11,					
	indicated residen	t #41 had a potential for					
	hyperglycemic o	r hypoglycemic episodes					
	secondary to diabetes. A goal for this						
	problem was for the resident to have no						
	signs and sympto	oms of					
	hypo/hyperglyce	mia daily. One					
	intervention for t	his problem was					
	medication and l	abs as ordered.					
	Physician's order	rs, dated 6/28/10					
	indicated Reside	nt #41 was to receive a					
	subcutaneous inj	ection of 40 units of					
	Lantus at bedtim	e, a Novolog injection of					
	12 units to be give	ven subcutaneously 3					
	1	30 A.M., 12:00 P.M., and					
	· ·	ne resident was to have					
	`	ood test to determine the					
	-	the blood) before meals					
		The order indicated that					
		s to be contacted if the					
		s were below 60 or above					
		indicated that a Novolog					
		ilin injection for insulin					
	_	be given based on					
	accucheck result	s between 201 and 400.					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
		155412	B. WING		07/15/2011	
NAME OF I	PROVIDER OR SUPPLIER		STREET	ADDRESS, CITY, STATE, ZIP CODE	!	
TVI IVIL OF I	ROVIDER OR SOLVER		937 FI			
GREENV	WOOD HEALTH AN	D LIVING COMMUNITY LLC	GREE	NWOOD, IN46142		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	``	ICY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION) The diabetic monitoring flowsheet for		TAG	BEI ICIENCI)	DATE	
		licated the resident's				
		lted in a range requiring				
	1	on the following dates				
	`	sliding scale ordered was				
	·	201-250 = 2 units,				
		4s, 301-350 = 6 units,				
	351-400 = 8 unit	s, 401-450= 10 units.)				
	5/20/11 + 7.20 4	1.5 2.40				
	5/20/11 at 7:30 A					
		nave been 6 units given -				
	none was listed	5.1. 400				
	5/22/11 at 12:00					
		have been 2 units given -				
	none was listed					
	5/28/11 at 12:00	P.M.=342				
	should h	nave been 6 units given -				
	none was listed					
	5/29/11 at 12:00	P.M. = 325				
	should h	nave been 6 units given -				
	none was listed					
	5/29/11 at 5:30 F	P.M. = 379				
	should h	nave been 8 units given -				
	none was listed					
	6/4/11 at 12:00 F	P.M. = 288				
	should h	nave been 4 units given -				
	none was listed					
	6/23/11 at 5:30 F	P.M. = 341				
	should h	nave been 6 units given -				
	none was listed	-				
	The diabetic mor	nitoring flowsheet,				
		nistration record, and the				
		the dates and times				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155412		(X2) MULTIPLE CO A. BUILDING B. WING	00	l` ´	E SURVEY PLETED /2011	
	PROVIDER OR SUPPLIER	D LIVING COMMUNITY LLC	937 FR	ADDRESS, CITY, STATE, ZIP Y RD IWOOD, IN46142	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	related to insulin	ked any information coverage having been by the physician based c results noted above.				
	7/14/11 at 2:45 F information was	requested regarding the k information as noted				
	review of the rec	OON indicated that after ords she could not find formation relating to for the above dates.				
	accucheck for Reindicating that the order of the accu	200 P.M., the result of the esident #41 was 265 to Povolog sliding scale check between 251 and points of insulin to be R on this date indicated open given.				
	accucheck for Reindicating that the order of the accumulation 350 required 6 units accumulation.	O P.M., the result of the esident #41 was 331 e Novolog sliding scale check between 301 and nits of insulin to be R on this date indicated been given.				
	An undated facil "Diabetes Mellit	ity policy, titled us - Routine Care,"				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155412		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 07/15/2011	
	PROVIDER OR SUPPLIER	D LIVING COMMUNITY LLC	STREET A	ADDRESS, CITY, STATE, ZIP CODE Y RD IWOOD, IN46142	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	7/13/11 at 10:00 To provide nursin for implementing with diabetes me provide care that to achieve and or diabetesAn abrigurose must be a continued on the provide care that to achieve and or diabetesAn abrigurose must be a continued on the provide care that to achieve and or diabetesAn abrigurose must be a continued on the continued of the provide care not limited or the pharmac indicated a recont discontinue Metromedication used emptying). The provide care the provide care of the provide care	himendation to oclopramide (a to promote gastric physician response /11 indicated the was accepted and for y to please execute ove. ly, 2011 MAR hinistration Record) for 7/12/11 at 10:30 a.m.			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155412		A. BUIL	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/15/2011		
	PROVIDER OR SUPPLIER	LIVING COMMUNITY LLC	1	STREET A	DDRESS, CITY, STATE, ZIP CODE / RD WOOD, IN46142	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
	dates: 7/7/11 thr time on 7/12/11.	ough 7/11/11 and one					
	7/12/11 at 4:40 p have been a miso indicated she tho recommendation in the chart with	ne Director of Nursing on o.m. indicated there must communication. She ought someone took the from the fax and filed it out writing an order for discontinue and without the MAR.					
	Review Form Co DON on 7/12/11 reviewed on 7/12 policy indicated recommendation physician, the nu and fax copy or p pharmacy, keep recommendation	Jedication Regimen ompletion provided by the at 11:15 a.m. was 2/11 at 11:25 a.m. The if the pharmacist is accepted by the arse will note the order othone order to the the original accepted in chart as an order if not and date form, and note fax					
	was reviewed on Physician's order that Resident #52 diet, NCS (no co NAS (no added s	ecord for Resident #52 7/12/11 at 9:45 A.M. rs dated 4/12/11 indicated 2 was to receive a regular encentrated sweets), and salt).					
		th open salt packets next					

	OF CORRECTION	IDENTIFICATION NUMBER:			NSTRUCTION 00	COMPI	
		155412	A. BUI B. WIN	LDING		07/15/2	2011
			D. WIN		DDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER			937 FR	Y RD		
GREENV	VOOD HEALTH AN	D LIVING COMMUNITY LLC		GREEN	WOOD, IN46142		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTIO		(X5)
PREFIX TAG	· `	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE	COMPLETION DATE
1710		en he was interviewed at	+	1710	<u> </u>		DATE
	· •	cated that he always put					
		nilk. His menu was					
	observed listing	that he was NCS. NAS					
	was not listed as	ordered by physician.					
		onducted with RN Unit					
	_	on 7/13/11 at 2:00 P.M.					
	when informatio	n was requested et change for Resident					
		ed that the diet listed for					
		rent diet and there had					
	been no changes						
	On 7/14/11 at 12	:50 P.M. Resident #52					
		ceiving his tray in his					
		ackets. The menu on the					
	l -	s menu was NCS. NAS					
	was not listed as	ordered by physician.					
	4. The record fo	r Resident #107 was					
	reviewed on 7/11						
		led but were not limited					
	to, tracheotomy	stoma (an opening in the					
		hat aides in breathing),					
	1 *	e, laryngeal resection					
	`	rynx), and Gastric-tube					
	placement.						
	Resident #107 w	as admitted to the facility					
		a physicians order to be					
		mouth). On 7/8/11 the					
		Language Pathologist					

NAME OF PROVIDER OR SUPPLIER GREENWOOD HEALTH AND LIVING COMMUNITY LLC (NAID SIMMARY STATEMENT OF DEFICIENCIES PREEN TAG (SLP) wrote an order indicating Resident #107 "may have sips of water after intensive oral care." A "Vitals Report" that included fluid intake, and the amount of fluid ingested, indicated Resident #107 received fluid by mouth on the following dates; 6/30/11, 480 cubic centimeters (ce's) (2 cups), 7///11, 120 ce's (1/2 cup), 7/4/11 120 ce's (1/2 cup), 7/8/11 120 ce's (1/2 cup), 7/4/11 120 ce's (1/2 cup) 7/8/11. An interview was held with the SLP on 7/14/11 at 3-00 p.m. She indicated she feels that Resident #107 can safely swallow small sips of water. An interview was held with DONS (Director of Nursing Services) on 7/14/11 at 4-30 p.m. She indicated she feels that Resident #100 can safely swallow small sips of water. An interview was held with DONS (Director of Nursing Services) on 7/14/11 at 4-30 p.m. She indicated she feels that Resident #100 can safely swallow small sips of water. An interview was held with DONS (Director of Nursing Services) on 7/14/11 at 4-30 p.m. She indicated she feels that resident #100 can safely swallow small sips of water. An interview was held with DONS (Director of Nursing Services) on 7/14/11 at 4-30 p.m. She indicated she feels that resident #100 can safely swallow small sips of water. An interview was held with DONS (Director of Nursing Services) on 7/14/11 at 4-30 p.m. She indicated she feels that resident #100 can safely swallow small sips of water. An interview was held with DONS indicated no other information was available in regards to fluid intake. 3.1-35(g)(2)	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) N	IULTIPLE CO	NSTRUCTION		(X3) DATE	
NAME OF PROVIDER OR SUPPLIER GREENWOOD HEALTH AND LIVING COMMUNITY LLC (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (LACH IDERICITY MIST IN PERCEDIA BY TUIL) TAG RECOLATORY OR SCI IDENTIFYING MFOREMATIONS (SLP) wrote an order indicating Resident #107 "may have sips of water after intensive oral care." A "Vitals Report" that included fluid intake, and the amount of fluid ingested, indicated Resident #107 received fluid by mouth on the following dates; 6/30/11, 480 cubic centimeters (ce's) (2 cups), 7/1/11, 120 ce's (1/2 cup), 7/2/11 120 ce's (1/2 cup), 7/3/11 120 ce's (1/2 cup), 7/	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDING	00		l	
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GREENWOOD HEALTH AND LIVING COMMUNITY LLC (MA) ID SUMMARY STATEMENT OF DEFICIENCIES REFERY TAG (SLP) WRITE AND GROUND HEALTH AND COMMUNITY LLC REGULADORY OR LSC (IDENTIFYING BRORMATION) (SLP) wrote an order indicating Resident #107 "may have sips of water after intensive oral care." A "Vitals Report" that included fluid intake, and the amount of fluid ingested, indicated Resident #107 received fluid by mouth on the following dates; 6/30/11, 480 cubic centimeters (ce's) (2 cups), 7/1/11, 120 ce's (1/2 cup), 7/2/11 120 ce's (1/2 cup), 7/3/11 120 ce's	NAME OF P	ROVIDER OR SUPPLIER			1		E, ZIP CODE		
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FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: ZYOR11 Facility ID: 000509 If continuation sheet Page 14 of 30	EODM CMC 2	567(02 00) P	na Ohaalata E (IS	7)/05:	4 10117-7	D: 000500	If postime it	haat 5	44 500

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155412			(X2) MU A. BUII B. WING	DING	00	(X3) DATE COMPI 07/15/2	LETED
GREENV		D LIVING COMMUNITY LLC		937 FR	ADDRESS, CITY, STATE, ZIP CODE Y RD IWOOD, IN46142		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
F0325 SS=E	assessment, the faresident - (1) Maintains accernutritional status, sprotein levels, unle condition demonst possible; and (2) Receives a the anutritional probleton 1. Based on recording the facility failed weight losses were sidents reviewed sample of 20. (R#25) 2. Based on observed received the aresident received aresident received ordered for 1 of 1 receiving diets as 20. (#52) Findings include 1. The record of reviewed on 7/13 a. Diagnoses for	to ensure significant re assessed for 4 of 7 ed for weight loss in a resident #3, #33, #13 and revation, interview and refacility failed to ensure ed a therapeutic diet as 12 residents reviewed for a ordered in a sample of the Resident #3 was	F0	325	F325 483.25(i) MAINTAIN NUTRITION STATUS UNLE UNAVOIDABLE I. Residents #3, #3 and #25 have been review for significant weight char Physician and family notification has been completed and residents # #33, #13, and #25 have be added to weekly at risk meeting and are being wei weekly. Resident #52's die was clarified with the phys during the survey process the NAS order was discontinued. Resident #5 receiving a diet as ordered the physician. II. All resident weigh have been reviewed via the weight variance report for last 6 months. Those foun have had significant weigh changes have been added	3, #13 ed oges. d3, en ghed t sician and 2 is I by ots e the d to out	08/14/2011

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155412	LDING	NSTRUCTION 00	l'	E SURVEY PLETED /2011
	PROVIDER OR SUPPLIER	D LIVING COMMUNITY LLC	 STREET A	ADDRESS, CITY, STATE, ZIP CODE Y RD IWOOD, IN46142	,	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRI DEFICIENCY)	O BE	(X5) COMPLETION DATE
	retardation, Edw and dementia with and dementia with A therapeutic diest resident, originate through August, problem of "Resimechanically altergoal was "Resided 50% of meals of included "Monitor month. Notify Maignificant weight sub[stitute] where consumed" A physician's order of 9/30/10 indicate receive "Resource nutritional dietar meal. Review of a Weight the facility's comparate a.m. indicated the facility's comparate a.m. indicated the resident #3: 5/11/11 - 79.0 per 6/10/11 - 69.0 per significant weight days 7/6/11 - 72.0 pour There was no door the resident with the resident weight days 1/10/11 - 72.0 pour There was no door the resident with the resident weight days 1/10/11 - 72.0 pour There was no door	ard's syndrome, epilepsy th severe agitation. It care plan for the ing 7/15/08 and updated 2011, indicated a dent requires a ered diet: Pureed." The ent will consume at least fered." Approaches or/record weight [each] ID and family of at changeOffer a <50% of meal is Her with an original date ted Resident #3 was to te Cup (Magic Cup)" (a by supplement) at every The consume at least for t		the weekly at risk meet weekly weights have be initiated as needed, and referrals have been man the dietician as necess resident diets will be at cross reference diet sliphysician orders for ac III. The systemic dincludes: a. A weekly weight vareport will be reviewed manager or designee for significant weight chan if identified will be re-w for accuracy. Any resid a significant weight chan if identified will be re-w for accuracy. Any resid a significant weight chan be reviewed in the weel risk meeting for appropriate in daily clinically meeting for community with dietary department. Education will be providenessed nursing staff of Matrix documentation regarding accuracy of variance of documentation and communication of dietary departments. Weight variance resonce weekly at the at rimeeting on an ongoing b. Diet orders change	de to ary. All idited to os and curacy. Change ariance by unit or ges and eighed ent with inge will kly at riate intons. Is will be all stand hication it. Ided to on weight ary artment.	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155412		A. BUIL	DING	NSTRUCTION 00	(X3) DATE SU COMPLE 07/15/20	TED	
		100412	B. WINC		ADDRESS, CITY, STATE, ZIP CODE	07710720	11
NAME OF I	PROVIDER OR SUPPLIE	R		937 FR			
		D LIVING COMMUNITY LLC		GREEN	IWOOD, IN46142		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
	+	d and addressed. The			new admission diet orders	in	
	most recent dietary note reviewing the				clinical stand up meeting w		
		ed 1/19/11. The next			Certified Dietary Manager of		
	weight for the re	esident was done on			designee for accuracy with cards five times weekly on		
	7/6/11.				ongoing basis.		
					The results of these review	s	
	h The record of	f Resident #33 was			will be discussed at the monthly facility Quality		
		4/11 at 2:00 p.m.			Assurance Committee mee	- 1	
		,			and frequency and duration reviews will be adjusted as		
	Diagnoses for R	esident #33 included, but			needed.		
	were not limited	to, depression, anxiety,			I. Completion date:		
	dementia with v	erbal abuse and			August 14, 2011.		
	aggression.						
		order for July, 2011, with					
		of 10/6/09 indicated the					
	resident was on	a mechanical soft diet.					
	A care plan for I	Resident #33, originating					
	7/15/08 and upd	ated through 8/2011,					
	1 ^	lem of "Requires					
		t: Mech[anical] Soft.					
		desident will consume at					
		als offered." Approaches					
		offer sub[stitute] when less					
	than 50% is cons						
	_	tnotify physician of of 5% in 30 days6.					
	Offer [bedtime] snack. 7. Supplement as needed"						
	Review of a Wei	ight Variance Report for					
		eived from the DoN on					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
		155412	B. WING		07/15/2011
	PROVIDER OR SUPPLIER	D LIVING COMMUNITY LLC	937 FF	ADDRESS, CITY, STATE, ZIP CODE RY RD NWOOD, IN46142	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	7/15/11 at 11:00 following weight 4/25/11: 244.0 p 5/14/11: 230 po 6/10/11: 238.6 p 7/6/11: 214.6 p The weight loss b 7/6/11 was a sign 10.1% in 1 month 1d) The record for reviewed on 7/13 Diagnoses include gastroesophageal stomach contents the throat), historic dysphasia (troubly rheumatoid lung, Resident #13 was loss. A weight loss. The June of 2011. From April Resident #10 may 11th, 20 was 159.4. The resident #10 may 11th, 2011 a weight of 133.7, loss, 19 % of her Further information DONS in regards.	a.m. indicated the as: ounds ounds ounds ounds ounds ounds oetween 6/10/11 and officant weight loss of the are not limited to, a reflux disease (gerd, as that come back up into ry of dehydration, le swallowing), and hypertension.			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155412		A. BUILI	DING	NSTRUCTION 00	(X3) DATE S COMPL 07/15/2	ETED	
		100112	B. WING		DDRESS, CITY, STATE, ZIP CODE		
NAME OF 1	PROVIDER OR SUPPLIEI	2		937 FR			
GREEN	WOOD HEALTH AN	D LIVING COMMUNITY LLC		GREEN	WOOD, IN46142		
(X4) ID		STATEMENT OF DEFICIENCIES	<u> </u>	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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IAG		ther information was	+	IAG			DATE
	available.	mer mornation was					
	C. The clinical	record for Resident #25					
	was reviewed or	n 7/12/11 at 10:00 a.m.					
	Diameter C. B.	:44-405 in al. 44-1. 4					
	1 –	esident #25 included, but to: Cerebral Palsy,					
		res, Anxiety, Depression,					
	and Dysphagia.	nes, miniety, Depression,					
	Review of the W	eight Variance Report					
	1 ^	DON (Director of					
	1	2/11 at 3:00 p.m. indicated					
		eight was 169.2 pounds on					
		.2 pounds on 6/10/11, a					
	6.5% weight los	s of 11 pounds in 27 days.					
	There was no do	cumentation to support					
		veight loss was assessed					
	and addressed.	8					
	1 1	recapitulation orders for					
	1	ated Resident #25 was to					
	have super cerea	al with breakfast.	-				
	2 The clinical re	ecord for Resident #52					
		107/12/11 at 9:45 A.M.					
		rs dated 4/12/11 indicated					
	1 -	2 was to receive a regular					
	diet, NCS (no co	oncentrated sweets), and					
	NAS (no added	salt).					
	0.7/10/11	05 A 3 6 D . 11					
	On 7/13/11 at 8:	35 A.M. Resident #52					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155412		(X2) MULTIPL A. BUILDING B. WING	E CONSTRUCTION 00	i i	E SURVEY PLETED 2011	
	PROVIDER OR SUPPLIER	D LIVING COMMUNITY LLC	937	EET ADDRESS, CITY, STATE, Z FRY RD EENWOOD, IN46142	ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	CROSS-REFERENCED TO	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
	to his plate. Whethis time he indicate salt in his buttern observed listing	th open salt packets next nen he was interviewed at cated that he always put milk. His menu was that he was NCS. NAS ordered by physician.				
	Manager, North, when informatio regarding any di #52. She indicat	et change for Resident red that the diet listed for rent diet and there had				
	On 7/14/11 at 12:50 P.M. Resident #52 was observed receiving his tray in his room with salt packets. The menu on the tray indicated his menu was NCS. NAS was not listed as ordered by physician.					
	Nursing Services 11:10 a.m. she ir Managers and sh Variance Reports gain is noted, the referred to the Ir supplements and be initiated. She loss or gain is no be reweighed an entered on the W	iew with the Director of (DoNS) on 7/14/11 at adicated the Unit the review the Weight so. If a significant loss or the resident would be atterdisciplinary Team, weekly weights would be indicated if a significant of the the resident should do this weight should be weight Variance Report.				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	onstruction 00	(X3) DATE SURVEY COMPLETED	
		155412	A. BUILDING B. WING		07/15/2011
NAME OF P	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
GREENV	VOOD HEALTH ANI	D LIVING COMMUNITY LLC	937 FR GREEN	Y KD IWOOD, IN46142	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION DATE
	in June, 2011 wa	s missed.			
	3.1-46(a)(1)				
	3.1 -4 0(a)(1)				
F0329		ug regimen must be free			
SS=D	drug is any drug w	drugs. An unnecessary hen used in excessive dose			
		e therapy); or for excessive it adequate monitoring; or			
	without adequate i	ndications for its use; or in			
	indicate the dose s	should be reduced or			
	discontinued; or an reasons above.	ny combinations of the			
	Based on a compr	ehensive assessment of a			
	resident, the facilit	y must ensure that			
		e not used antipsychotic n these drugs unless			
		therapy is necessary to ndition as diagnosed and			
	documented in the	clinical record; and			
		antipsychotic drugs receive ctions, and behavioral			
	interventions, unle	ss clinically contraindicated, ontinue these drugs.			
		rd review and interview	F0329	F329 483.25(I) DRUG REGIN	
	the facility failed			IS FREE FROM UNNECESS DRUGS	ARY
		gical measures were steed prior to giving an		I. Resident #3 is no	
	antianxiety medi	1 0 0		I. Resident #3 is no longer receiving as needed	

NAME: OF PROVIDER OR SUPPLIER GREENWOOD HEALTH AND LIVING COMMUNITY LLC IX31 D SUMMARY STATEMENT OF DETICIENCY TAG REGULATORY OR LSC IDENTIFYING INFORMATIONS) TREGILATORY OR LSC IDENTIFYING INFORMATIONS TREGILATORY OR LSC IDENTIFYING INFORMATIONS) Tresidents reviewed for not being offered alternatives to antiamxiety medication therapy in a sample of 20. (Resident #3) 2. Based on record review and interview the facility failed to ensure a resident no longer received a medication after it was discontinued by the physician for 1 of 17 residents reviewed for medications being discontinued in a sample of 20. (Resident #25) Findings include: 1. The record of Resident #3 was reviewed on 7/13/11 at 10:20 a.m. Diagnoses for Resident #3 included, but were not limited to, profound mental retardation, Edward's syndrome, dementia with severe agitation, anxiety and self mutilation. A care plan for the resident, with an original date of 12/15/10 and updated 6/29/11, indicated a problem of "Resident has repetitive physical movementsfidgeting in w/c [wheelchair], picking at skin, sucking/biting fingers, banging hands on	NAME OF PROVIDER OR SUPPLIER GREENWOOD HEALTH AND LIVING COMMUNITY LLC	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:			(X2) MULTIPLE C	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED
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A care plan for the resident, with an original date of 12/15/10 and updated 6/29/11, indicated a problem of "Resident has repetitive physical movementsfidgeting in w/c [wheelchair], picking at skin, sucking/biting fingers, banging hands on designee. The Director of Nursing or designee will distribute recommendations to the unit managers and a copy will be returned to the Director of Nursing or designee, to monitor for completion.	designee. The Director of Nursing or designee will distribute recommendations to the unit managers and a copy will be returned to the Director of Nursing or designee, vo movementsfidgeting in w/c [wheelchair], picking at skin, sucking/biting fingers, banging hands on tray." Approaches to the problem include reassuring and comforting the resident during acute periods, establishing a designee. The Director of Nursing or designee will distribute recommendations to the unit managers and a copy will be returned to the Director of Nursing or designee, to monitor for completion.		A				
6/29/11, indicated a problem of "Resident has repetitive physical movementsfidgeting in w/c [wheelchair], picking at skin, sucking/biting fingers, banging hands on distribute recommendations to the unit managers and a copy will be returned to the Director of Nursing or designee, to monitor for completion.	6/29/11, indicated a problem of "Resident has repetitive physical movementsfidgeting in w/c [wheelchair], picking at skin, sucking/biting fingers, banging hands on tray." Approaches to the problem include reassuring and comforting the resident during acute periods, establishing a distribute recommendations to the unit managers and a copy will be returned to the Director of Nursing or designee, to monitor for completion. Education will be provided to licensed nursing staff regarding the new format non physmacological.		1 *	·		designee. The Director of	
has repetitive physical movementsfidgeting in w/c [wheelchair], picking at skin, sucking/biting fingers, banging hands on the unit managers and a copy will be returned to the Director of Nursing or designee, to monitor for completion.	has repetitive physical movementsfidgeting in w/c [wheelchair], picking at skin, sucking/biting fingers, banging hands on tray." Approaches to the problem include reassuring and comforting the resident during acute periods, establishing a the unit managers and a copy will be returned to the Director of Nursing or designee, to monitor for completion. Education will be provided to licensed nursing staff regarding the new format non physical		_	•		1 -	4-
movementsfidgeting in w/c [wheelchair], picking at skin, sucking/biting fingers, banging hands on will be returned to the Director of Nursing or designee, to monitor for completion.	movementsfidgeting in w/c [wheelchair], picking at skin, sucking/biting fingers, banging hands on tray." Approaches to the problem include reassuring and comforting the resident during acute periods, establishing a will be returned to the Director of Nursing or designee, to monitor for completion. Education will be provided to licensed nursing staff regarding the new format non pharmacological					1	•
[wheelchair], picking at skin, sucking/biting fingers, banging hands on of Nursing or designee, to monitor for completion.	[wheelchair], picking at skin, sucking/biting fingers, banging hands on tray." Approaches to the problem include reassuring and comforting the resident during acute periods, establishing a of Nursing or designee, to monitor for completion. Education will be provided to licensed nursing staff regarding the new format non pharmacological.					I -	
sucking/biting fingers, banging hands on	sucking/biting fingers, banging hands on tray." Approaches to the problem include reassuring and comforting the resident during acute periods, establishing a Education will be provided to licensed nursing staff regarding the new format non pharmacological.						
	tray." Approaches to the problem include reassuring and comforting the resident during acute periods, establishing a Education will be provided to licensed nursing staff regarding the new format] ·			monitor for completion.	
,, , appropried to the progress signed	reassuring and comforting the resident during acute periods, establishing a licensed nursing staff regarding the new format non pharmacological					Education will be provided	l to
	during acute periods, establishing a regarding the new format		1	•		I -	
during acute periods, establishing a regarding the new format	l l non nharmacological			•		regarding the new format	
l non nharmacological	Lusting relationship, assisting the restdent					non-pharmacological	

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO LDING	INSTRUCTION 00	(X3) DATE SURVEY COMPLETED
		155412	B. WIN			07/15/2011
	PROVIDER OR SUPPLIER	D LIVING COMMUNITY LLC	'	937 FR	ADDRESS, CITY, STATE, ZIP CODE Y RD IWOOD, IN46142	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
	maintaining a cal approach to the r familiar routines. Another care plan 9/17/10 and upda problem of "Resi	n, with an original date of sted 6/29/11, had a dent has socially			intervention prior to the use antianxiety agents and the pharmacy recommendation procedure. IV. The Director of Nursing or designee will review/audit: a. All residents with as needed antianxiety medicate.	new
	symptoms as evidencises, banging hand moaning." In but were not limicalm environment over-stimulation measures for bas	ruptive behavioral denced by making loud hands on tray, crying out interventions included, ted to maintaining a ht, avoiding and providing comfort ic needs ("i.e., pain, too hot/cold, etc.")			five times weekly for 1 mon then three times weekly for month, then once weekly for month, then once monthly duration of 12 months for non-pharmacological intervention prior to use. b. The pharmacy recommendations for completion once weekly on ongoing basis. The results of these review	or 1 for
	2011, with an ori indicated the resi Diazepam (an an every 4 hours as agitation and/or by	tianxiety medication) needed "for increased			will be discussed at the monthly facility Quality Assurance Committee mee and frequency and duratior reviews will be adjusted as needed. V. Completion date: August 14, 2011.	ting n of
	for June, 2011, ir Diazepam for bit 6:45 p.m., 6/25 a p.m., 6/27 at 3:00 a.m. There was n resident's record non-pharmacolog	ing his hands on 6/24 at t 10:30 a.m. and 5:00 p.m. and 6/28 at 11:00 o documentation in the				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:			(X2) MI	ULTIPLE CO	NSTRUCTION	(X3) DATE S COMPL	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155412	A. BUII		00	07/15/2	
		100+12	B. WIN		DDDEGG CITY GTATE ZID CODE	0771072	011
NAME OF F	PROVIDER OR SUPPLIER			937 FR	ADDRESS, CITY, STATE, ZIP CODE		
GREENV	VOOD HEALTH AND	D LIVING COMMUNITY LLC		I	IWOOD, IN46142		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΤE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	the Diazepam.						
	the Regional Cor 11:55 a.m. titled indicated "Policy interventions will manage behavior During an intervi Nursing on 7/14/ indicated she was further information pharmacological attempted for Res him the anti-anxi	ity policy, received from a sultant on 7/14/11 at "Psychotropic Drug Use" aNon-pharmacological I be utilized first to as when appropriate" The with the Director of 11 at 10:00 a.m. she is unable to provide on on whether non interventions had been sident #3 prior to giving the ety medication. She already started working this."					
		ecord for Resident #25 7/12/11 at 10:00 a.m.					
	were not limited	esident #25 included, but to: Cerebral Palsy, res, Anxiety, Depression,					
	from the pharmad indicated a recon discontinue Meto medication used	nmendation to oclopramide (a to promote gastric physician response					

I		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155412	(X2) MULTIPLE CO	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 07/15/2011
NAME OF PROVIDER OR SUPPLIER GREENWOOD HEALTH AND LIVING COMMUNITY LLC			937 FF	ADDRESS, CITY, STATE, ZIP CODE RY RD NWOOD, IN46142	1
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	recommendation was accepted and for nursing/pharmacy to please execute request noted above.				
	Review of the July, 2011 MAR (Medication Administration Record) for Resident #25 on 7/12/11 at 10:30 a.m. indicated Metoclopramide was administered three times on the following dates: 7/7/11 through 7/11/11 and one time on 7/12/11.				
	Interview with the Director of Nursing on 7/12/11 at 4:40 p.m. indicated there must have been a miscommunication. She indicated she thought someone took the recommendation from the fax and filed it in the chart without writing an order for the pharmacy to discontinue and without transcribing it to the MAR.				
	Review Form Co DON on 7/12/11 reviewed on 7/12 policy indicated recommendation physician, the nu and fax copy or p pharmacy, keep to recommendation	dedication Regimen ompletion provided by the at 11:15 a.m. was 2/11 at 11:25 a.m. The if the pharmacist is accepted by the arse will note the order ohone order to the the original accepted in chart as an order if not and date form, and note fax			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155412	(X2) MULTIPLE (A. BUILDING B. WING	OO	(X3) DATE SURVEY COMPLETED 07/15/2011
NAME OF F	PROVIDER OR SUPPLIER			T ADDRESS, CITY, STATE, ZIP CODE	
GREENV	VOOD HEALTH ANI	D LIVING COMMUNITY LLC	I	ENWOOD, IN46142	
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	*	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIATE	
F0371 SS=F		om sources approved or ctory by Federal, State or nd			
	(2) Store, prepare, under sanitary con 1. Based on obse the facility failed pureed eggs were at a temperature of Fahrenheit (F) or resident was serve potential of affect receiving a regular kitchen and 9 resident from 2. Based on obserview, the facility under sanitary corresidents receiving North dining roots 1. During an obset temperature check Director of Dining	distribute and serve food diditions rvation and interview, to ensure fish and held on the steam table of 135 degrees greater until the last red. This had the ting 84 residents ar diet served from the idents receiving a the South Dining Room. ervation and record ty failed to feed residents anditions for 1 of 6 ng pureed food in the m. ervation of food ks in the kitchen with the ng Services after the last	F0371	F371 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY I. Fish and pureed of are held on the steam table temperature of 135 degrees Fahrenheit or greater until last resident is served. C.N #1 was educated/counseled during survey to proper resident feeding standards II. Food temperature be monitored with each me service by dietary staff and audited by Certified Dietary Manager for accuracy. Aud will be conducted at randomeal times by the unit man or designee for proper feed technique of residents. III. The systemic characterists	eggs at a s the .A. d . will al its m ager ling
	Director of Dinin			III. The systemic char includes:	nge

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **ZYOR11** Facility ID:

000509

If continuation sheet

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY COMPLETED	
		155412	A. BUII	LDING	00	07/15/2011	
		100+12	B. WIN			01/13/2011	
NAME OF F	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
ODEEN!!				937 FR	Y RD WOOD, IN46142		
	ENWOOD HEALTH AND LIVING COMMUNITY LLC			GREEN	WOOD, IN46142		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
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TAG			+	TAG		DATE	
	• •	emaining fish on the			 a. A log sheet will be utili to monitor holding 	zeu	
		red a temperature of 120			temperatures with each me	al	
		g interview at that time			service.		
		ining Services indicated			b. Breaded meat items wi	II be	
		It should be warmer than			placed in a perforated pan		
	that."				broth placed under to facili	tate	
					proper food temperatures.		
	During an observ	ration of food			 c. Nursing staff will be educated regarding proper 		
	temperature chec	ks in the South Dining			feeding technique of reside	ents.	
	Room with the D	rirector of Dining					
	Services after the last resident was served breakfast on 7/13/11 at 8:55 a.m., the remaining pureed eggs on the steam table showed a temperature of 130 degrees F. During interview at that time the Director of Dining services indicated at this time they had just had their steam table				Education will provided to		
					dietary staff regarding		
					temperature monitoring.		
					Education will be provided	I	
					nursing staff on proper feet technique of residents.	aing	
					teeninque of residents.		
					IV. The Director of Dir	ning	
	repaired and she didn't "know why they're				Services or designee will		
not staying warn					review/audit:		
	not staying warner.				a. Food temperature logs	I	
					completed by dietary staff taccuracy and completion. I		
					addition the Certified Dieta	I	
					Manager will complete rand	•	
					food temperature audits wi		
					meal service three times		
					weekly for 1 month, then or		
					weekly for 4 months, and the	I	
					once monthly for a duration 12 months.	1 OT	
					14 monuis.		
					The Director of Nursing or		
					designee will review/audit:		
					-		
					a. Meal service for prope	I	
					feeding technique three tim		
					weekly for 1 month, then or	1Ce	
FORM CMS-2	567(02-99) Previous Versio	ns Obsolete Event ID: 7	YOR11	Facility I	D: 000509 If continuation s	heet Page 27 of 30	

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3)			(3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBI		IDENTIFICATION NUMBER:	A. BUILDING 00		COMPLETED		
155412		B. WINC			07/15/2011		
NAME OF I	DROLUDED OD GLIDDLIEI	2		STREET A	ADDRESS, CITY, STATE, ZIP CODE	l	
NAME OF PROVIDER OR SUPPLIER				937 FR	Y RD		
		D LIVING COMMUNITY LLC			IWOOD, IN46142		
(X4) ID		STATEMENT OF DEFICIENCIES	1.	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
PREFIX TAG	·	NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	'	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE	ON
		,		-	weekly for 1 month, then of monthly for duration of 12		
					months.		
					The results of these audits be discussed at the month		
					facility Quality Assurance	,	
					Committee meeting and		
					frequency and duration of		
					reviews will be adjusted as needed.		
					V. Completion date: August 14, 2011		
	2 On 7/13/11 a	t 8:35 a.m. Resident #25					
	was observed eating breakfast in the North dining room. CNA #1 was feeding Resident #25 what appeared to be hot cereal. Prior to feeding a spoonful to						
		NA #1 put her face near					
	· ·	lew on it. Before feeding					
	_	e next spoonful, CNA #1					
		r the spoon and blew on it					
	as well.	the spoon and view on it					
	us well.						
	Review of the N	utrition and Hydration					
		ulum provided by the					
		sing on 7/15/11 at 9:30					
		ed on 7/15/11 at 3:20 p.m.					
		serving food, the CNA					
		oods to cool them.					
	3.1-21(i)(3)						
	(-)(-)						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155412		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING B. WING 00 07/15/2011						
NAME OF PROVIDER OR SUPPLIER GREENWOOD HEALTH AND LIVING COMMUNITY LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 937 FRY RD GREENWOOD, IN46142					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
F0425 SS=E	emergency drugs residents, or obtain described in §483 facility may permit administer drugs in under the general nurse. A facility must proviservices (including accurate acquiring administering of a meet the needs of a licensed phan consultation on all pharmacy services. Based on observe the facility failed disposed of after affected 4 of 16 minimulin Resident. Findings Include The "south hall in on 7/15/11 at 9:3 insulin were four	mploy or obtain the services macist who provides aspects of the provision of in the facility. Action and record review, at to ensure insulin was expiration dates. This residents who received #'s, 22, 29, 59, and 79.	F0425	F425 483.60(a),(b) PHARMACEUTICAL SVC — ACCURATE PROCEDURES RPH I. Resident #22, #29, # and #79 insulin was dispos of and replaced during the survey process. II. All residents receiving insulin have been identified and th vials have been reviewed for expiration date and date opened. No expired insulin were found. III. The system change includes: a. Licens nursing staff will be educat on the importance of dating	eed or s nic sed			

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155412		A. BUI	LDING	00 	COMPLE 07/15/20	ETED	
NAME OF PROVIDER OR SUPPLIER GREENWOOD HEALTH AND LIVING COMMUNITY LLC			B. WING O7713/2011 STREET ADDRESS, CITY, STATE, ZIP CODE 937 FRY RD GREENWOOD, IN46142				
	SUMMARY S (EACH DEFICIEN REGULATORY OR One vial of Leve Resident #79. O Insulin belonged The "north, 100 l observed on 7/15 vials of insulin w indicated they w past their origina Novolog Insulin #22. One vial of belonged to Resi A facility policy p.m., un-dated an Dates For Certain	D LIVING COMMUNITY LLC TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) mir Insulin, belonged to ne vial of Novolog to Resident #59. mall" medication cart was f/11 at 10:00 a.m. Two were found with dates that ere more than 28 days I open dates. One vial belonged to Resident Novolog Insulin dent #29. reviewed on 7/15/11 at 5 and titled " Expiration in Drugs, Biologicals, and atted that Insulin expires		937 FR	Y RD	and te ch n will prior h uick n will ulin gnee ay onth, nth, k for nthly s. will ly	(X5) COMPLETION DATE